Celanese Chiropractic Health & Performance
Dr. Clay Gasparovich

1924 Mt Gallant Rd
Rock Hill, SC 29732
P: (803) 323-5500

PATIENT INFORMATION

Full Name ______________________ Birth Date ______________ Gender M F
Address ______________________ SS# _____ - _____ - _____ Work Phone ______________
City ____________ State ____ Zip ______ Cell Phone ______________ ____
In order to receive text reminders, please provide phone carrier (AT&T, Verizon, etc.) ______________

Marital Status S M W D Sep / Spouse Name ______________________ Birth Date ____________
Are you a student? Y N / Full-time Part-time
Your Employer ______________________________ Your Occupation ______________________
Employer Address ____________________ City ________________ State ______ Zip ________
Spouse's Employer ___________________________ Spouse's Occupation ______________________

INSURANCE (Please allow our staff to photocopy your current license & health insurance card (s)).

Email: ______________________ **Referred by:** ______________________________

Family History

Please take a few moments to complete the following. The better you fill out, the better it will help us to treat your condition. Thanks for your cooperation.

Place an "X" in any box that may apply.

	Mother	Father	Brother	Sister	Children	Spouse
Back Pain						
Neck Pain						
Headaches						
Pinched Nerve						
Scoliosis						
Arthritis						
Numbness						
Cold Hands/Feet						
Carpal Tunnel						
Sport Injuries						

- I authorize payment of medical benefits to this office
- I will allow this office to treat me, with other health care providers present, and to record my medical information, including consultation and examination, for documentation purposes if necessary.
- I give this office the right to use my name for any in-office publications.
- Authorization may be denied or retracted by notifying the office manager.
- I acknowledge having the right to review and obtain a copy of the notice of privacy practices of this office. (Once information is disclosed, it may not be protected by law.)

Patient's Signature ________________________________ Date ____________
Spouse's or Guardian's Signature ________________________ Date ____________
(Authorization expires 3 years from date above)

CASE HISTORY

History of Present Injury/Illness

Please list below the complaint(s) you have in the order of importance. Also the length of time you have had these complaints.

1. ______________________________ How long?________
2. ______________________________ How long?________
3. ______________________________ How long?________
4. ______________________________ How long?________

Is your condition(s) related to an accident? ☐ YES ☐ NO

Date of accident: __________ State: ______ Type of Accident: ☐ Auto ☐ Work Related ☐ Other__________

What words would best describe your condition(s)? (ex. ache, burn)__________

Circle the number that matches your level of pain at its worst (0=no pain, 10=most severe)

0 1 2 3 4 5 6 7 8 9 10

When is your condition most severe? __________

When is your condition least severe? __________

What makes your condition feel worse? __________

What makes your condition feel better? __________

What activities are difficult because of your condition(s)? __________

Have you seen any other health care provider for your present condition? ☐ Yes ☐ No

Who? __________

Current Medications__________

Are you or could you be pregnant? ☐ YES ☐ NO

Are you experiencing or do you have any of the following?

☐ A sore that won't heal
☐ Any bleeding/discharge
☐ Bladder/ bowel problems
☐ Difficulty swallowing
☐ Lump/thickening anywhere
☐ Night pain
☐ Persistent cough/hoarseness
☐ Wart/mole changes
☐ Weight loss without trying
☐ **None of the above**

Review of Systems

In addition to the symptom(s)/dysfunctions(s) listed above, are you experiencing any of the following?

Neuromusculoskeletal System

☐ Anxiety
☐ Atrophy
☐ Concussion
☐ Depression
☐ Difficulty walking
☐ Dizziness
☐ Extremity deformity
☐ Facial drooping
☐ Headache
☐ Joint deformity
☐ Joint locking
☐ Joint swelling
☐ Lack of coordination
☐ Limited range of motion
☐ Loss of balance
☐ Memory loss
☐ Mood swings
☐ Muscle weakness
☐ Numbness
☐ Popping noises
☐ Psychiatric disorders
☐ Seizures
☐ Sensory changes
☐ Speech problems
☐ Stiffness
☐ Tremors
☐ Twitches
☐ Vision trouble
☐ **None of the above**

Cardiovascular System

☐ Ankle Swelling
☐ Blood Clots
☐ Carotid blockage
☐ Changes in skin color
☐ Chest Pain
☐ Dizziness
☐ Fainting
☐ Hypertension
☐ Jaw pain
☐ Known vascular
☐ Mitral valve prolapse
☐ Phlebitis
☐ Pin stroke
☐ Previous stroke
☐ Shortness of breath
☐ Varicose veins
☐ **None of the above**

Past History

List any surgeries you have had (including appendix, tonsils, wisdom teeth, etc.)

1.__________ Date ______ 3.__________ Date ______

2.__________ Date ______ 4.__________ Date ______

Have you ever been hospitalized for anything in addition to surgeries? ☐ YES ☐ NO

If so, when and for what reason? __________

Have you ever been diagnosed as having a particular condition? (Diabetes, heart trouble, cancer)

☐ YES ☐ NO __________

Are you currently under a doctor's care for conditions other than the ones you are seeking care for?

☐ YES ☐ NO __________

CELANESE CHIROPRACTIC HEALTH & PERFORMANCE

AUTHORIZATION TO RELEASE INFORMATION

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released you must sign this form. Signing this form will only give consent to release this information to the individuals indicated below. This consent form will not allow Celanese Chiropractic Health & Performance to release any other information to these individuals.

You have the right to revoke this consent in writing.

I authorize/allow Celanese Chiropractic Health & Performance to release my medical and/or billing information to the following individual(s):

1. ________________________________ Relation to Patient:__________________

2. ________________________________ Relation to Patient:__________________

3. ________________________________ Relation to Patient:__________________

Patient Name:____

Patient Signature:____________________________ Date:__________________________

AUTHORIZATION TO LEAVE MESSAGES WITH HOUSEHOLD MEMBERS/ANSWERING MACHINE:

Occasionally it is necessary for the staff of Celanese Chiropractic Health & Performance to leave messages for patients. The purposes of these messages is to remind patients that they have an appointment, to notify the patient that the medical staff would like to discuss or schedule test results, or to ask a patient to call regarding an issue or concern. At no time will a representative of Celanese Chiropractic Health & Performance discuss your medical condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine.

You have the right to revoke this consent in writing.

Patient Name:____

Patient Signature:____________________________ Date:__________________________

*For Office Use Only: Patient ID*________________

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FINANCIAL HARDSHIP WAIVER

Patient Name____

Phone____

Address____

City_______________________ State______________ Zip____________

For the reason checked below, I am unable to pay the unreimbursed medical charges due to economic hardship. In addition, I do not have a guardian or other responsible party who can assist me with these expenses. Please explain: (Mark all that apply)

__ Unemployed

__ No Insurance

__ Bankrupt

__ Student

__ Other:____

__ Not Covered by State or Local Welfare Program

__ Dependent on Family for Support

__ High Medical Expenses

__ Low or Fixed Income

Patient Signature_________________________________ Date________________

OFFICE USE ONLY

I waive the collection of unreimbursed medical charges on the above mentioned patient/family:

Authorized Signature______________________________ Date________________

ELECTION TO NOT CLAIM HEALTH INSURANCE

The staff has informed me that if I file on my own health insurance, I will be responsible for paying deductibles and co-payments and that any such payments will be due as treatment is received. The staff has provided me with factual information regarding the various forms of reimbursement available to me and has answered my questions.

I have decided that I do not wish to file any claim on my health insurance. I hereby direct and authorize the clinic to send bills and treatments records only to me, my attorney, the liability insurance carrier, or to my own automobile insurer for the purpose of receiving payment under my Medical Payments, Uninsured or Under-Insured Motorist coverage, if applicable. I am aware that if I have instructed this facility to send any information to my attorney, adjuster, or third party persons that I must first sign a separate and distinct release that is in accordance with HIPAA.

I understand that the clinic will rely on my decision and render treatment based on the assumption that payment will be received from sources other than my health insurance. I will not be expected to pay deductibles and co-payments, however will be billed at the clinic's usual rates rather than at discounted rates that may apply to in-network providers.

I understand that contractual and statutory deadlines may prevent me from filing on my health insurance at a later date and that I should consider the decision I am making today not to file on my health insurance to be irreversible. I also understand that any penalties that Celanese Chiropractic Health & Performance may incur, as a result of non-timely filing, will be assigned to the patient.

FOR ALL PERSONAL INJURY RELATED CLAIMS

I understand that if for any reason, my liability claim is ultimately denied, compromised or litigated unsuccessfully, I will remain personally liable for the reasonable value of the treatment rendered to me by the clinic and for any difference in settlement payments.

______________________________ ______________

Patient Signature Date

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Witness